



George Phillips, DMD  
 T. Gregory Phillips, DDS



Please give your DENTAL INSURANCE Information or card to the receptionist.

Welcome to our office!

**THANK YOU FOR COMPLETING THE FOLLOWING CONFIDENTIAL INFORMATION.**

Name(Mr. Mrs. Ms. Dr. Rev.) \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-Mail-Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work# \_\_\_\_\_ Ext \_\_\_\_\_ Cell# \_\_\_\_\_

Birth date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Is another member of your household a patient at our office? \_\_\_\_\_

**Whom may we thank for referring you?** \_\_\_\_\_

Or how did you hear about us? (*circle*) Yellow Pages Location Relative Co-Worker Doctor Internet Other

Person to contact for emergency \_\_\_\_\_

Their Phone & Address: \_\_\_\_\_

**EMPLOYER & FINANCIAL**

Person responsible for account: Self Other- Relation: \_\_\_\_\_

Responsible's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ **May we call you at work?** \_\_\_\_\_

Employer Address \_\_\_\_\_ Suite # \_\_\_\_\_

**MEDICAL INFORMATION**

Are you under a physician's care now? Yes No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury? Yes No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you have osteoporosis or other bone condition? Yes No

**Women:** Are you:  
 Pregnant/Trying to get pregnant? Yes No  
 Nursing? Yes No  
 Taking oral contraceptives? Yes No

Are you **ALLERGIC** to any of the following? (Please Circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other Allergies & Explanations: \_\_\_\_\_

Do you have, or have a recent history of, any of the following? (Please Circle)

- |                        |                           |                       |                       |                            |
|------------------------|---------------------------|-----------------------|-----------------------|----------------------------|
| AIDS/HIV Positive      | Chest Pains               | Frequent Headaches    | Irregular Heartbeat   | Scarlet Fever              |
| Alzheimer's Disease    | Cold Sores/Fever Blisters | Genital Herpes        | Kidney Problems       | Shingles                   |
| Anaphylaxis            | Congenital Heart Disorder | Glaucoma              | Leukemia              | Sickle Cell Disease        |
| Anemia                 | Convulsions               | Hay Fever             | Liver Disease         | Sinus Trouble              |
| Angina                 | Cortisone Medicine        | Heart Attack/Failure  | Low Blood Pressure    | Spina Bifida               |
| Arthritis/Gout         | Diabetes                  | Heart Murmur          | Lung Disease          | Stomach/Intestinal Disease |
| Artificial Heart Valve | Drug Addiction            | Heart Pace Maker      | Mitral Valve Prolapse | Stroke                     |
| Artificial Joint       | Easily Winded             | Heart Trouble/Disease | Pain in Jaw Joints    | Swelling of Limbs          |
| Asthma                 | Emphysema                 | Hemophilia            | Parathyroid Disease   | Thyroid Disease            |
| Blood Disease          | Epilepsy or Seizures      | Hepatitis A           | Psychiatric Care      | Tonsillitis                |
| Blood Transfusion      | Excessive Bleeding        | Hepatitis B or C      | Radiation Treatments  | Tuberculosis               |
| Breathing Problem      | Excessive Thirst          | Herpes                | Recent Weight Loss    | Tumors or Growths          |
| Bruise Easily          | Fainting Spells/Dizziness | High Blood Pressure   | Renal Dialysis        | Ulcers                     |
| Cancer                 | Frequent Cough            | Hives or Rash         | Rheumatic Fever       | Venereal Disease           |
| Chemotherapy           | Frequent Diarrhea         | Hypoglycemia          | Rheumatism            | Yellow Jaundice            |

Have you ever taken any of the **bisphosphonates**, such as Boniva, Areida, Fosamax, Bondronat, Actonel or Zometa? Yes No

*Please continue questions on next page*

Please expand on the items you circled on last page if needed. Also, is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain: \_\_\_\_\_

## DENTAL HEALTH & APPEARANCE

What is the *primary* concern you would like us to address first? \_\_\_\_\_

Approximate date of last dental visit: \_\_\_\_\_

Have you ever had any serious problem associated with previous dental treatment? Yes  No

Is so, explain: \_\_\_\_\_

What, if anything, has happened in previous experiences at the dentist that was reason not to return? \_\_\_\_\_

### Do you have any of the following? (circle)

Tenderness while chewing	Head, neck or face pain	Food catches between teeth	Pain when biting
Sensitivity to sweets	Clicking or popping of jaw	Tender or bleeding gums	Swellings or sores in mouth
Sensitivity to hot or cold	Clinch or grind teeth	Missing teeth	Snore regularly

If you have missing teeth, have you had them replaced? \_\_\_\_\_

If you have had missing teeth replaced, are you happy with the results? \_\_\_\_\_

Do you feel (or have you ever been told) that you don't have fresh breath? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss (routinely)? \_\_\_\_\_

## COSMETIC EVALUATION

Are you happy with your smile? \_\_\_\_\_

Please rate your smile from 1 to 10 (1= I hate my smile, 10= awesome) \_\_\_\_\_

If you could, what, if anything, would you change about your smile? \_\_\_\_\_

### If you would like an improved smile please check off all that apply:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Lighten all front teeth showing | <input type="checkbox"/> Rebuild fracture(s) | <input type="checkbox"/> Straighten rotation   | <input type="checkbox"/> Eliminate dark or stained fillings |
| <input type="checkbox"/> Lighten single tooth            | <input type="checkbox"/> Lengthen            | <input type="checkbox"/> Straighten angulation | <input type="checkbox"/> Reduce gum showing in smile        |
| <input type="checkbox"/> Close spaces between teeth      | <input type="checkbox"/> Shorten             | <input type="checkbox"/> Eliminate crowding    | <input type="checkbox"/> Repair uneven edges                |

### We respect your right to choose the level of care that fits your needs. Please check all that apply to you:

- I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.
- Spreading payments out over time may help me to achieve the excellent results I desire.
- Phasing treatment, by priority, over a few years may make it feasible for me to achieve the results I desire.
- I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
- Although I am not interested in a plan for long-term dental health, I do desire an office that will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

Please add anything you feel is important: \_\_\_\_\_

## Authorization and Consent

1. To the best of my knowledge, all of the preceding answers are true, complete, and correct. I hereby authorize Dr. Phillips to take necessary radiographs(X-rays), study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize him to perform treatment, therapy or medication deemed necessary by the doctor and agreed upon by the patient. I understand that the use of anesthetic agents or nitrous oxide gas embodies a certain risk.

2. I also understand that responsibility for payment for dental services provided for myself and my dependents is mine and is due and payable at the time services are rendered. There may be additional charges for late payments, broken appointments, returned checks and collection costs.

3. I understand that it is necessary to give **24 hours** prior notice to change or cancel any dental appointment in order to avoid charges or fees for a broken appointment. For appointments of 2 or more hours please give a 48 hour notice.

4. **INSURANCE:** I understand that any insurance estimates given to me by Dr. Phillips' office are estimates and cannot be a guarantee of payment by my insurance company. I understand that I am responsible for the entire balance. I give Dr. Phillips permission to give my insurance company any information that is necessary to process my insurance claim.

I would like my insurance company to pay: Me  Dr. Phillips

Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

I am the  Patient  Parent/Guardian of Patient

Doctor Reviewed \_\_\_\_\_